GREENWOODDENTALSMILES
MARK GLEIXNER, DDS | BEN DIEKHOFF, DDS

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Please take a few minutes to complete the following information and answer the questions.

Legal Name (if different from above) _____ Male ☐ Female ☐ Birthdate _____

Marital Status ☐S ☐M ☐D ☐W ☐Sep Spouse's name: _____Employer:_____ Work phone: _____

SS# _____ Your Employer: _____ Occupation: _____

Employer Address:_____

Please complete insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed.

	Primary coverage		Secondary coverage	
Insured Party:	_____	Birthdate___	_____	Birthdate_____
SS#	_____		_____	
ID# (if applicable)	_____		_____	
Employer/plan:	_____		_____	
Insurance company:	_____		_____	
Address:	_____		_____	
Phone:	_____		_____	

In case of Emergency, please contact:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Contact person living at different mailing address:

Name: _____ Phone: _____ Relationship _____

Who may we thank for referring you to our office ? _____

I authorize the staff of Mark E. Gleixner, D.D.S. to perform any necessary services needed during diagnosis and treatment. I also authorize Mark E. Gleixner, D.D.S. to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____Date: _____

Please check one: ☐Adult patient ☐Parent or Guardian ☐Spouse

For office use only: *Entered into computer by (initials):* _____ *Date:* _____

MEDICAL HISTORY

Medical Doctor:_____ City / Phone:_____

List all medications you are currently taking, and why you are taking them: _____

_____

Are you ***allergic*** to any of the following drugs?

Y☐N☐ Penicillin Y☐N☐ Tetracycline Y☐N☐ Erythromycin
Y☐N☐ Aspirin Y☐N☐ Codeine Y☐N☐ Dental Anesthetics
Y☐N☐Latex

Please List ***All Other Allergies*** to Medications or Other:

_____

_____

Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? **Y / N**

Please List Any *Surgeries or Hospitalizations* You Have Had:_____

_____

Are you pregnant or nursing? Y / N (Due date: _____) Are you taking birth control pills? Y / N

Do you use tobacco? Y / N Type: Smoke / Chew / Dip How often? _____ For how many years? _____

Do you have headaches, back pain or neck pain? Y / N How often? _____ Severity? _____

Do you have or have you had any of the following conditions? (Circle Y or N)

Y☐N☐ Heart attack/stroke
Y☐N☐Cosmetic Surgery
Y☐N☐Shingles
Y☐N☐Liver Problems
Y☐N☐Rheumatic Fever
Y☐N☐ Asthma
Y☐N☐ Arthritis/ Rheumatism
Y☐N☐ Stomach Problems/Ulcers
Y☐N☐ Heart Disease
Y☐N☐Leukemia
Y☐N☐Fainting/ Seizures/ Epilepsy
Y☐N☐ Alcohol/ Drug Abuse
Y☐N☐ Scarlet Fever
Y☐N☐ Bleeding Problems
Y☐N☐TMJ/TMD

Y☐N☐Thyroid problems
Y☐N☐ Heart Surg./ Pacemaker
Y☐N☐ Xray or Cobalt Treatment
Y☐N☐ Hepatitis(A, B or C) Please circle
Y☐N☐ Respiratory Problems
Y☐N☐ Mitral Valve Prolapse
Y☐N☐ Difficulty Breathing
Y☐N☐ Artificial Bones/ Joints
Y☐N☐ Psychiatric Problems
Y☐N☐ Congenital Heart Defect
Y☐N☐ Anemia
Y☐N☐ Glaucoma
Y☐N☐ Tuberculosis (TB)
Y☐N☐ Nervousness

Y☐N☐ Cancer or Tumors
Y☐N☐ Kidney Problems
Y☐N☐ Heart Murmur
Y☐N☐ Chemotherapy
Y☐N☐ HIV / AIDS / ARC
Y☐N☐ Sinus Problems
Y☐N☐ Artificial Heart Valves
Y☐N☐Diabetes
Y☐N☐ Emphysema
Y☐N☐ Venereal Disease
Y☐N☐Chest Pains
Y☐N☐High Blood Pressure
Y☐N☐Low Blood Pressure
Y☐N☐ Hypoglycemia

Please list any other medical conditions not listed:_____

_____

Is there anything you want to talk to the doctor about today?

_____